

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>390073</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>07/20/2023</b>
NAME OF PROVIDER OR SUPPLIER: <b>UPMC ALTOONA</b>  STATE LICENSE NUMBER: <b>012801</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>620 HOWARD AVENUE ALTOONA, PA 16601</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
P 0000	<p>INITIAL COMMENT</p> <p>This report is the result of an unannounced onsite complaint investigation (CHL23C446J) completed on July 20, 2023, at UPMC Altoona Hospital. It was determined that the facility was in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Hospitals, 28 PA Code, Part IV, Subparts A and B, November 1987, as amended June 1998.</p>	P 0000			

(X6) DATE:



# Certified End Page

**UPMC ALTOONA**

**STATE LICENSE NUMBER: 012801**

**SURVEY EXIT DATE: 07/20/2023**

**I Certify This Document to be a True and Correct Statement of Deficiencies and  
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

*Jeane Parisi*  
*Deputy Secretary for Quality Assurance*

A handwritten signature in black ink that reads "Debra L. Bogen MD".

*Debra L. Bogen, MD, FAAP*  
*Acting Secretary of Health*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY